Home Health Agency Services

4.231 ~~7401~~ Home Health Agency Services ~~(04/01/1999, 98-11F)~~

~~Home health agencies provide a variety of services including skilled nursing, therapies, aide services and medical social work to beneficiaries in their home.~~

4.231.1 Definitions

(a) **"Home health agency"** means a public or private agency or organization, or part of either, that meets the requirements for participation in Medicare, and complies with the Vermont regulations for the designation and operation of home health agencies.

(b) **"Home health agency services"**, for the purposes of this rule, means the services described at 4.231.2(a) that are provided by a home health agency.

~~This definition is consistent with the federal definition found at 42 CFR 440.70.~~

~~7401.1 Eligibility for Care (04/01/1999, 98-11F)~~

~~Coverage for home health agency service is provided to beneficiaries of any age. Coverage for targeted case management services is limited to at-risk children ages one to five.~~

~~7401.2~~4.231.2 Covered Services ~~(02/26/2011, 10-13)~~

(a) Home health agency services are covered when medically ~~-~~necessary. Services that are covered include~~that have been pre-approved for coverage are limited to~~:

(1) ~~skilled~~ Nnursing ~~care~~ services,
(2) Hhome health aide services,
(3) Mmedical supplies, ~~equipment and appliances suitable for use in the home~~ and durable medical equipment,
~~(2)~~(4) Physical therapy, occupational therapy, or speech language pathology services, ~~rehabilitative therapy service~~ands,~~(as specified in Rule 7317.3);~~
~~(3) medical supplies, equipment and appliances, suitable for use in the home and~~
~~(4)~~(5) ~~targeted case management.~~Medical social work services.

~~7401.5~~4.231.3 Qualified Providers ~~(02/26/2011, 10-13)~~

(a) Home health agency ~~-~~providers must be~~a~~ Medicare ~~id~~ certified ~~provider~~ and ~~be~~ enrolled ~~with~~in Vermont Medicaid.

(b) Home health agency services must be ordered by a physician who is enrolled in Vermont Medicaid and working within the scope of his or her practice.

~~(b)~~(c) The following non-physician practitioners (NPP) may perform the face-to-face encounter as required in 4.231.4(c) of this rule:

(1) A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the ordering physician, or
(2) A physician assistant under the supervision of the ordering physician.

(d) For beneficiaries admitted to home health agency services immediately after an acute or post-acute stay, the attending acute or post-acute physician may perform the face-to-face encounter.

4.231.4 Conditions for Coverage ~~(02/26/2011, 10-13)~~

~~(a) Home health care services are covered when the conditions for Medicare (Part A or Part B) payment are met or when all of the following conditions are met.~~

(a) General Conditions

(1) Home health agency services are not limited to services furnished to beneficiaries who are homebound. ~~For Medicaid reimbursement, there is no homebound restriction, nor is a three-day prior hospitalization required.~~

(2) Coverage of home health agency services are not contingent upon the beneficiary needing nursing or therapy services.

~~(2)~~(3) The ~~patients~~beneficiary's condition ~~may~~ shall be either an episode of acute illness or injury, or a chronic condition requiring part time or intermittent home health care ~~under a physician's order~~.

~~Payment for home health services will not be made to any agency or organization that is operated primarily for the care and treatment of a mental disease.~~

(b) ~~Requirement for a Written~~ Plan of Care Requirements

(1) Items and services shall be~~are~~ ordered ~~and furnished~~ under a written plan of care ~~,~~ approved ~~signed~~ by the ~~attending~~ ordering physician ~~and incorporated into the agency's permanent record for the patient~~. ~~The~~ The plan of care shall include the following:

~~relates the items and services to the patient's condition as follows:~~

(A) ~~The plan includes~~ Tthe diagnosis, and a description of the patient's functional limitation resulting from illness, injury, or condition,

(B) ~~It specifies~~ Tthe type and frequency of medically necessary~~needed~~ home health services, ~~, ie, nursing services, drugs and medications, special diet, permitted activities, therapy services, home health aide services, medical supplies and appliances.~~

(C) A~~It provides a~~ long-range forecast of likely changes in the patient's condition,

~~(D) It specifies changes in the plan in writing, signed by the attending physician or by a registered professional nurse on the agency staff pursuant to the physician's oral orders, and~~

~~(E)~~(D) The ordering physician's certification that the services and items specified in the plan of care can be provided through a home health agency.

(2) Initial orders for home health services shall include documentation that the face-to-face visit occurred, as required in 4.231.4(c).

(3) Any changes in a plan of care shall be signed by the physician, or by a registered nurse on the agency staff pursuant to the physician's oral orders.

~~(2)~~(4) The plan of care shall be ~~is~~ reviewed by the ~~attending~~ physician, in consultation with ~~professional~~ home health agency personnel, at least every ~~62~~ 60 days.

~~(a) , or more frequently as the severity of the patient's condition requires, and shows the day of each review and physician's signature.The attending physician certifies that the services and items specified in the treatment plan can, as a practical matter, be provided through a home health agency in the patient's place of residence.~~

(c) Face-to-Face Visit Requirements

(1) For the initiation of home health agency services, the ordering physician or NPP must conduct a face-to-face encounter with the beneficiary no more than 90 days prior to, or 30 days after, the start of service.

(2) The face-to-face encounter must be related to the primary reason the beneficiary requires home health agency services.

(3) The face-to-face encounter may be conducted in person or through telemedicine.

(4) The ordering physician must document:

(A) That the face-to-face encounter is related to the primary reason the beneficiary requires home health agency services,
(B) That the face-to-face encounter occurred within the required timeframe,
(C) The practitioner who conducted the encounter, and
(D) The date of the encounter.

(5) The NPP performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

(d) Location Where Service is Provided

(1) ~~The service or item is~~Home health agency services ~~furnished in the beneficiary's home~~may be received in any setting in which normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (unless such services are not otherwise required to be provided by the facility)~~)~~, or any setting in which payment could be made under Medicaid for inpatient services that include room and board. ~~. A place of residence includes beneficiary's own dwelling; an apartment; a relative's home; a place where patients or elderly people congregate such as senior citizen or adult day center; a community care home; and a hospital or nursing home.~~

(2) An initial assessment visit to determine the need for home health agency services may be performed b~~visit b~~y a registered nurse or appropriate therapist ~~to observe and evaluate a beneficiary either~~ in ~~the~~a hospital, nursing home, or community setting. ~~for the purpose of determining the need for home health services is covered.~~

~~(e) Coverage of Initial Visit~~

~~An initial visit by a registered nurse or appropriate therapist to observe and evaluate a beneficiary either in the hospital, nursing home or community for the purpose of determining the need for home health services is covered. If physician ordered treatment is given during the initial visit, the two services may not be charged separately.~~

~~Requirements Specific to Nursing Care~~

~~Nursing care services are covered when the services are related to the care of patients who are experiencing acute or chronic periods of illness and those services are:~~

~~(1) ordered by and included in the plan of treatment established by the physician for the patient; and~~

~~(2) required on an intermittent basis; and~~

~~(3) reasonable and necessary to the treatment of an illness, injury or condition.~~

~~(f)~~(e) Requirements Specific to Home Health Aide Services

(1) Services of a home health aide are covered ~~when assigned~~ in accordance with a written plan of ~~treatment~~ care ~~established~~ ordered by a physician and supervised by a registered nurse, physical therapist, occupational therapist, or speech language pathologist.

(2) ~~or appropriate therapist.~~ T~~Under appropriate supervision, t~~he home health aide may provide medical assistance, personal care, ~~,~~ assistance in ~~the~~ activities of daily living, ~~such as helping the patient to bathe, to care for hair or teeth, to~~ assistance with a home exercise program, and ~~to re~~training the beneficiary ~~the patient in necessary~~in self-help skills.

(3) ~~In cases where home health aides are assigned to patients requiring specific therapy, the home health aide must be supervised by the appropriate therapist; however, it is not necessary in these cases to require an additional supervisory visit by the nurse to supervise the provision of personal services.~~ T~~During a particular visit, t~~he home health aide may perform household chores ~~(such as changing the bed, light cleaning, washing utensils, assisting in food preparation)~~ that are incidental to the ~~visi~~visit, and specific to the beneficiary.~~t.~~

~~(1)~~(4) Supervisory visits by a registered nurse or appropriate therapist must be performed at least every 60~~2~~ days.~~, and more frequently if necessary.~~

(f) Requirements Specific to Medical Supplies

(1) Medical supplies are covered when they are needed to treat the ~~essential for enabling home health agency personnel to effectively carry out the care and treatment that has been ordered for the patient~~ beneficiary in accordance with ~~by~~ the physician-ordered plan of care ~~and used during the visit~~.

(2) Routine medical supplies used during the usual course of most home visits are included in the home visit charges and not reimbursed separately.

(3) The coverage limitations specific to medical supplies described elsewhere in rule apply to medical supplies provided by a home health agency.

~~These items include catheters, needles, syringes, surgical dressings, and materials used for dressings such as cotton gauze and adhesive bandages. Other medical supplies include, but are not limited to, irrigating solution, and intravenous fluids and oxygen. Certain supplies are not covered; see rule 7401.5.~~

(g) Requirements Specific to Durable Medical Equipment

(1) The rental of certain durable medical equipment (DME) owned by the home health agency and required in the beneficiary's plan of care is covered when conditions of coverage for DME are met.) ~~included on the list of DME items pre-approved for coverage (see Rule 7505.2), that the home health agency owns and is used by a patient as part of the plan of care, is covered when the conditions of coverage, where applicable, as described in Rule 7505.3 are met. Coverage of rental of a specific item of DME may be subject to prior authorization~~

~~(1)~~(2) ~~(see Rule 7505.4).~~ The DME coverage limitations described elsewhere in r~~R~~ule ~~7505.5 also~~ apply to DME provided by a home health agency.

~~(h) Requirements Specific to Targeted Case Management Services~~

~~Targeted case management services are provided only to children ages one to five who are at risk for unnecessary and avoidable medical interventions and who do not have another primary case management provider whose responsibility is to provide or coordinate the interventions included in this service. The Vermont Department~~

~~of Health will review and determine how many targeted case management visits shall be authorized to at-risk children ages one to five.~~

~~(i)~~(h) Requirements Specific to Therapy Services

(1) P~~P~~hysical therapy~~,~~, occupational therapy, and speech language pathology ~~, and speech therapy~~ services are covered for up to four months per medical condition, based on a physician's order. Provision of these services beyond this initial four-month period requires prior authorization. ~~–~~Therapy services must be:

~~•~~ D~~d~~irectly related to an active treatment regimen designed or approved by the physician, and require ~~; and~~

~~(A) of such~~ a level of complexity ~~and sophistication~~ such that the judgment, knowledge, and skills of a qualified therapist are required~~,~~; and

(A)

(B) R~~r~~easonable and necessary under accepted standards of medical practice for~~to~~ the treatment of the patient's condition.

(2) The physical therapy, occupational therapy, and speech language pathology services described elsewhere in rule apply to therapy services provided by a home health agency.

~~Therapy services provided outside the home and requiring equipment that cannot be brought to the home are covered provided that the agency has met certifying standards for that service under Medicare 7401.4 Non-Covered Services (02/26/2011, 10-13)~~

~~With the exception of services authorized for coverage via rule 7104, services not included under rule 7401.2 and services that do not meet criteria specified in rules 7401.2 7401.4, where applicable, are not covered.~~

~~Routine low-cost medical supplies, such as cotton balls and tongue depressors, are deemed to be included~~

~~in the home visit charges and will not be paid for separately.~~

~~7401.6 Reimbursement (02/26/2011, 10-13)~~

~~Reimbursement for home health agency services is described in the Provider Manual. If all conditions for Medicare are met and the patient is Medicare eligible, Medicare must be billed before Medicaid reimbursement is requested.~~